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5% Maximum Claim Form

My out-of-pocket maximum is: $_____
Parent/Guardian Name: _____
Health Plan:_____

We have provided this form to help you keep track of your children's medical and dental services. After your out-of-pocket maximum is met, return this form to CHIP (see below). Complete one line for each co-payment or co-insurance you pay. You do not need to submit receipts, but keep them for your records.

You may submit claim forms up to one year after the end of the plan year in which the expenses occur. The plan year is July 1 - June 30.

Child's Name	Date of visit or claim	Did you pay this bill? Y/N	Health Care Provider's Name and Mailing Address	Amount of co-pay or co-insurance
			Subtotal on this page:	

Grand Total (for all pages) $_____

Return form to:
CHIP, PO Box 144102, SLC, UT 84114-4102
Fax: 801-538-6860
E-mail: chip@utah.gov

Child's Name	Date of visit or claim	Did you pay this bill? Y/N	Health Care Provider's Name and Mailing Address	Amount of co-pay or co-insurance
			Subtotal on this page:	

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